Group Name:
KENTUCKY TEACHERS' RETIREMENT SYSTEM

Group Number: Q0697

Print Date: 03/20/07

Quote Keys:

Prospect:	015650009
Proposal:	357938
Demo:	01
Quote:	01

Market Office Name: HHCP-LEXINGTON

Additional Information:

PLEASE RETAIN THIS GROUP CONTRACT FOR YOUR RECORDS.

KENTUCKY TEACHERS' RETIREMENT SYSTEM MEDICARE ELIGIBLE HEALTH PLAN

SUMMARY PLAN DESCRIPTION / EVIDENCE OF COVERAGE

GROUP NUMBER: Q0697

EFFECTIVE JANUARY 1, 2007

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PLAN DESCRIPTION INFORMATION

1. Proper Name of *Plan*: Kentucky Teachers' Retirement System
   Medicare Eligible Health Plan

2. *Plan Sponsor*:

   Kentucky Teachers' Retirement System
   479 Versailles Road
   Frankfort, Kentucky 40601
   Telephone: (502) 848-8500

3. Plan Administrator and Named Fiduciary:

   Kentucky Teachers' Retirement System
   479 Versailles Road
   Frankfort, Kentucky 40601
   Telephone: (502) 848-8500

4. *Plan Sponsor* Identification Number: 61-0863412P

5. The *Plan* provides medical benefits for participating *covered persons*.

6. *Plan* benefits described in this booklet are effective January 1, 2007.

7. The *Plan year* is January 1 through December 31 of each year.

8. Service of legal process may be served upon the Plan Administrator as shown above or the following agent for service of legal process:

   Kentucky Teachers' Retirement System
   Attention: Executive Secretary
   479 Versailles Road
   Frankfort, Kentucky 40601

9. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Manager* is:

   Humana Insurance Company
   500 West Main Street
   Louisville, Kentucky 40202
   Telephone: Refer to *your* ID card

10. This is a self-insured and self-administered health benefit plan. The cost of the *Plan* is paid with contributions shared by the *Plan Sponsor* and *covered person*. Benefits under the *Plan* are provided from the *Plan's* restricted assets and are used to fund payment of covered claims under the *Plan* plus administrative expenses. Please see *your Plan Sponsor* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this *Plan*.

Plan Description Information Continued

11. Each *covered person* of the *Plan Sponsor* who participates in the *Plan* receives a Summary Plan Description / Evidence of Coverage, which is this booklet. Although it is the responsibility of the *Plan Sponsor*, the *Plan Manager* will assist the *Plan Sponsor* with providing the Summary Plan Descriptions to the *covered persons.* It contains information regarding eligibility requirements, termination provisions, and a description of the benefits provided and other *Plan* information.

12. The *Plan* benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the *Plan Sponsor*. Significant changes to the *Plan*, including termination, will be communicated to participants as required by applicable law.

13. Upon termination of the *Plan*, the rights of the participants to benefits are limited to claims incurred and payable by the *Plan* up to the date of termination.

14. This *Plan* is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

SCHEDULE OF BENEFITS

AN IMPORTANT MESSAGE ABOUT YOUR PLAN

Services are subject to all provisions of the *Plan*, including the limitations and exclusions.

Italicized terms within the text are defined in the Definitions section of this booklet.

Considering that participants of this *Plan* can have just *Medicare* Part A or Part B, or neither Part A or B, we have included the following guidance relative to how *your* claims will be processed.

1. **For members that have *Medicare* Part A only:** Claims will be paid by *Medicare* according to Part A guidelines and Kentucky Teachers' Retirement System will pay secondary to Part A according to the applicable benefit.
2. **For members that <u>do not</u> have *Medicare* Part A:** *Medicare* Part A expenses are rendered to the Provider which are calculated at 95% of the billed amount minus applicable deductibles and *copayments* then minus any amount Part B pays. The member will be responsible for the 5% plus any applicable deductibles and *copayments*.
3. **For members that have *Medicare* Part B only**: Claims will be paid by *Medicare* according to Part B guidelines and Kentucky Teachers' Retirement System will pay secondary to Part B according to the applicable benefit.
4. **For members that <u>do not</u> have *Medicare* Part B**: Claims will be estimated by the *Plan Manager* based on what *Medicare* Part B would have paid and the member will be responsible for that amount. Kentucky Teachers' Retirement System will pay secondary to what Part B would have paid per the applicable benefit.

The covered *services* listed in the Schedule of Benefits in this section are covered only when *all* requirements listed below are met:

1. *Services* must be provided according to the *Medicare* coverage guidelines established by the *Medicare* program.
2. *You* can get covered benefits from any provider qualified to furnish the benefit in question and who is willing to accept this Plans terms and conditions of payment. If you have any questions about what services this Plan will pay, please call Customer Service. Your Plan does not have to pay for services that are excluded.
3. The medical care, *services*, supplies, and equipment that are listed as covered *services*, must be *medically necessary*. Certain preventive care and screening tests are also covered.

Covered expenses are payable on a *maximum allowable fee* basis. Inpatient Hospital, inpatient *mental disorder*, chemical dependence and alcoholism expenses, Skilled Nursing Facility and Long Term Acute Care Facility expenses and flu and pneumonia vaccinations do not apply to the deductible shown on the Schedule of Benefits. Outpatient surgery *copayment* and *prescription drugs* do not apply to the out-of-pocket limits shown on the Schedule of Benefits.

Benefits Chart A list of covered services

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services

Benefits Chart - Your Covered Services

Inpatient Services

Inpatient hospital care

You are covered for an unlimited number of days. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical therapy, occupational therapy, and speech therapy services. • Under certain conditions, the following types of transplants are covered: Corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. All transplant services must be performed in a facility that is Medicare approved. For more information call 1-866-421-5663 (Humana Transplant Management) Monday-Friday 8:30 a.m.-5 p.m. EST. For corneal transplants call 1-877-511-5000. • Blood -Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need. • Physician Services.	YOU PAY $250 PER ADMISSION. YOU WILL ONLY BE CHARGED THE COPAYMENT ONCE IN A 60 DAY BENEFIT PERIOD. IN ADDITION, YOU PAY 4% COINSURANCE FOR PHYSICIAN'S SERVICES RECEIVED AT A MEDICAL OR SURGICAL FACILITY.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Inpatient mental health care Includes mental health care services that require a hospital stay. THERE IS A190-DAY LIFETIME LIMIT FOR INPATIENT SERVICES IN A PSYCHIATRIC HOSPITAL. THE 190-DAY LIMIT DOES NOT APPLY TO MENTAL HEALTH SERVICES PROVIDED IN A PSYCHIATRIC UNIT OF A GENERAL HOSPITAL. • Physician Services.	YOU PAY $250 PER ADMISSION. YOU WILL ONLY BE CHARGED THE COPAYMENT ONCE IN A 60 DAY BENEFIT PERIOD. IN ADDITION, YOU PAY 10% COINSURANCE FOR PHYSICIAN'S SERVICES RECEIVED IN A MENTAL HEALTH INPATIENT FACILITY.
Skilled nursing facility care You are covered for 100 days per benefit period. Prior hospital stay is not required. (A benefit period begins the day you go to a skilled nursing facility. The benefit period ends when you have not received skilled nursing care for 60 days in a row.) Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood -Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	YOU PAY NOTHING FOR DAYS 1-20. YOU PAY $24 PER DAY FOR DAYS 21-100.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Home health care Home Health Agency Care: • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	YOU PAY NOTHING.
Hospice care • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not elected the hospice benefit.	WHEN YOU ENROLL IN A MEDICARE-CERTIFIED HOSPICE, YOUR HOSPICE SERVICES ARE PAID BY MEDICARE.
Outpatient Services	
Physician services, including doctor office visits • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Outpatient hospital services. • Non-routine dental care provide by a dentist (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor). • Chemotherapy services. • Drugs administered in a physician's office.	YOU PAY A 4% COINSURANCE FOR EACH PHYSICIAN'S OFFICE VISIT. YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.
Chiropractic services • Manual manipulation of the spine to correct subluxation.	YOU PAY A 4% COINSURANC FOR EACH SPECIALIST'S OFFICE VISIT.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Podiatry services • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.
Outpatient mental health care (including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	YOU PAY A 10% COINSURANCE FOR EACH PHYSICIAN'S OFFICE VISIT. YOU PAY A 10% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT. YOU PAY 10% FOR EACH PARTIAL HOSPITALIZATION. YOU PAY 10% FOR EACH OUTPATIENT HOSPITAL VISIT.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Outpatient substance abuse services	YOU PAY A 10% COINSURANCE FOR EACH PHYSICIAN'S OFFICE VISIT. YOU PAY A 10% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT. YOU PAY 10% FOR EACH PARTIAL HOSPITALIZATION. YOU PAY 10% FOR EACH OUTPATIENT HOSPITAL VISIT.
Outpatient surgery	YOU PAY A 4% COINSURANCE FOR NON-SURGICAL VISITS AT AN OUTPATIENT HOSPITAL AND A $125 COPAYMENT FOR SURGICAL VISITS AT AN OUTPATIENT HOSPITAL. YOU WILL ONLY BE CHARGED THE $125 COPAYMENT ONCE IN A 60 DAY BENEFIT PERIOD.
Ambulance services Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	YOU PAY A 4% COINSURANCE PER DATE OF SERVICE.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Emergency care THIS COVERAGE IS WITHIN THE U.S. OR WORLD-WIDE.	YOU PAY A 4% COINSURANCE FOR EACH VISIT TO THE EMERGENCY ROOM UP TO A $50 MAXIMUM. EMERGENCY ROOM COPAYMENT IS NOT WAIVED IF YOU ARE ADMITTED TO THE HOSPITAL. YOU PAY A 4% COINSURANCE FOR EACH VISIT TO AN IMMEDIATE CARE CENTER.
Urgently needed care THIS COVERAGE IS WITHIN THE U.S. OR WORLD-WIDE.	YOU PAY A 4% COINSURANCE FOR URGENT CARE IN ALL SETTINGS.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum. **Benefits Chart - Your Covered Services**	**What you must pay** when you get these covered services
World wide coverage (for care that is not urgent or emergent)	YOU PAY 20% COINSURANCE UP TO A MAXIMUM ALLOWABLE PLAN BENEFIT OF $5,000. EMERGENCY SERVICES DO NOT APPLY TO MAXIMUM ALLOWABLE PLAN BENEFIT, BUT DOES APPLY TO THE MAXIMUM OUT-OF-POCKET. WORLD WIDE COVERAGE FOR CARE THAT IS NEITHER URGENT NOR EMERGENT DOES NOT APPLY TO THE MAXIMUM OUT OF POCKET.
Outpatient rehabilitation services (Physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy) Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	YOU PAY A 4% COINSURANCE IN ALL SETTINGS.
Durable medical equipment and related supplies This includes wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	YOU PAY 4% COINSURANCE.
Prosthetic devices and related supplies (other than dental) which replace a body part or function These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery - see "Vision Care" below for more detail.	YOU PAY 4% COINSURANCE.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Diabetes self-monitoring, training and supplies For all people who have diabetes (insulin and non-insulin users). • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per plan year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or insert. • Self-management training is covered under certain conditions. • For persons at risk of diabetes: Fasting plasma glucose tests, as often as is medically necessary.	YOU PAY 4% ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Medical nutrition therapy For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	YOU PAY 4% ONCE YOUR DEDUCTIBLE HAS BEEN MET.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Outpatient diagnostic tests and therapeutic services and supplies • X-rays. • Radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood -Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.	YOU PAY A 4% COINSURANCE FOR ALL SERVICES EXCLUDING OUTPATIENT LAB SERVICES. YOU PAY NOTHING FOR ALL OUTPATIENT LAB SERVICES ONCE YOUR DEDUCTIBLE HAS BEEN MET.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Preventive Care and Screening Tests	
Bone mass measurements • For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, the following are covered: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, the following is covered: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Immunizations	
• Pneumonia vaccine.	YOU PAY NOTHING.
• Flu shots, once a year in the fall or winter. You can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider).	YOU PAY NOTHING.
• If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine.	YOU PAY 4% ONCE YOUR DEDUCTIBLE HAS BEEN MET.
• Other vaccines if you are at risk.	YOU PAY 4% ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Mammography screening (You can get this service on your own, without a referral from your PCP): • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Pap smears, pelvic exams, and clinical breast exam For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. If you are at high risk of cervical cancer, or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).	YOU PAY A 4% COINSURANCE FOR CARDIOVASCULAR DISEASE TESTING.
Other Services	
Physical exams ONE PHYSICAL EXAMINATION PER YEAR.	YOU PAY NOTHING WHEN NO OTHER SERVICES ARE PROVIDED. YOU PAY 4% IF OTHER SERVICES ARE PROVIDED.
Renal Dialysis (Kidney) • Outpatient dialysis treatments. • Inpatient dialysis treatments (if you are admitted to a hospital for special care. • Self-dialysis training (includes training for you and others for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply).	YOU PAY A 4% COINSURANCE PER SESSION FOR OUTPATIENT RENAL DIALYSIS SERVICES.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Prescription Drugs THAT ARE COVERED UNDER ORIGINAL MEDICARE. THESE DRUGS ARE COVERED FOR EVERYONE WITH MEDICARE. "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. Kentucky Teachers' Retirement System Medicare Eligible Health Plan also covers some drugs that are "usually not self-administered" even if you inject them at home. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Kentucky Teachers' Retirement System Medicare Eligible Health Plan. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen^{R}) or Epoetin Alfa, and Darboetin Alfa (Aranesp^{R}). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	YOU PAY 4% FOR PART B DRUGS AT A RETAIL PHARMACY AND 4% FOR DRUGS ADMINISTERED IN A PHYSICIAN'S OFFICE. PLEASE CONTACT YOUR GROUP BENEFITS ADMINISTRATOR (KENTUCKY TEACHERS' RETIREMENT SYSTEM) FOR ADDITIONAL PHARMACY BENEFITS (IF APPLICABLE).
Additional Benefits	
Dental services • Services by a dentist limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.

Lifetime Maximum: $1,500,000 per *covered person*. **Deductible:** You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Hearing services • Diagnostic hearing exams (non-routine).	YOU PAY A 4% COINSURANCE FOR DIAGNOSTIC EXAMS.
Vision care • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.

CASE MANAGEMENT

CASE MANAGEMENT

The Case Management program is available to all members and is provided at no cost to *you*. *You* will be able to access a nurse case manager, who will assist and guide *you*:

- Calls after discharge from the hospital to help *you* and or *your* family with any unforeseen problems;
- Assist *you* with understanding and maximizing *your* benefits;
- Disease Management Program Education & Referrals;
- Access to a social worker who can provide guidance with social or financial challenges.

DISEASE MANAGEMENT

The Disease Management Programs listed in this section are available to *you*. These Disease Management Programs are provided at no cost to *you*.

- Peripheral Artery Disease
- Cerebrovascular Disease/Stroke
- Congestive Heart Failure
- Coronary Heart Disease
- Diabetes
- Hypertension
- Asthma
- COPD (Chronic Obstructive Pulmonary Disease)
- Gastro Esophageal Reflux Disease (GERD)
- Chronic Hepatitis
- Peptic Ulcer Disease
- Inflammatory Bowel Disease (Crohn's Disease and Ulcerative Colitis)
- Seizure Disorders
- Migraines
- Parkinsonism
- Rheumatoid Arthritis
- Osteoporosis
- Osteoarthritis
- General Cancer
- Breast Cancer
- Lung Cancer
- Lymphoma/Leukemia
- Prostate Cancer
- Colorectal Cancer
- Cystic Fibrosis
- Chronic Kidney Disease
- High Cholesterol
- Hypercoagulable State
- Chronic Low Back Pain

Case Management Continued

- Sickle Cell Disease
- Weight Management
- End Stage Renal Disease (ESRD)

If *you* have any questions regarding the Disease Management Programs listed in this section, contact 1-800-660-3457 and one of the nurses will assist *you*.

Certain programs may not be offered in all states or to all lines of business. Specific programs and vendors may change at the *Plan Manager's* sole discretion.

ACTIVEHEALTH MANAGEMENT

The *Plan Manager* has contracted with Active Health Management, Inc. to provide the CareEngine℠ Service in connection with *Plan* provisions aimed at monitoring quality, containing costs, and promoting efficient delivery of covered services. This is not a utilization review, precertification or professional consultation service. The assistance provided through this service does not constitute the practice of medicine.

The CareEngine℠ Service, uses a computer-assisted program which analyzes available medical and hospital claims, pharmacy and laboratory data according to evidence-based clinical rules and identifies members who may benefit from specific clinical interventions called Care Considerations which result in care improvement suggestions.

Care Considerations are communicated to the member through Physician messaging and Member messaging. Physician messaging will be used by Active Health Management, Inc. to communicate the Care Consideration to the treating physician via phone, fax, or letter to suggest a change in the patient's treatment. Member messaging will be used to communicate to the member in the form of a letter using 'patient friendly' language emphasizing the same Care Consideration suggestions approximately two weeks after the initial letter reaches the treating physician.

None of the services performed by ActiveHealth Management, Inc. constitute a claims review determination or a guarantee of coverage or benefits eligibility. Benefits eligibility will be determined in the normal course of claims processing.

PREDETERMINATION OF MEDICAL BENEFITS

You or *your qualified practitioner* may submit a written request for a *predetermination of benefits*, but this is not a requirement. The written request should contain the treatment plan, specific diagnostic and procedure codes, as well as the expected charges. The *Plan Manager* will provide a written response advising if the *services* are a *covered* or non-*covered expense* under the *Plan*, what the applicable *Plan* benefits are and if the expected charges are within the *maximum allowable fee*. The *predetermination of benefits* is not a guarantee of benefits. *Services* will be subject to all terms and provisions of the *Plan* applicable at the time treatment is provided.

If treatment is to commence more than 180 days after the date that the predetermination of benefits is issued, the *Plan Manager* will require *you* to submit another predetermination of benefits.

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION

Covered expenses are payable, after satisfaction of the deductible, to a *maximum allowable fee* at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits. *

DEDUCTIBLE

The deductible applies to each *covered person* each *calendar year*. Only charges which qualify as *covered expenses* may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits. *

COINSURANCE

The term coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the self-insured plan.

Covered expenses are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each *calendar year*.

OUT-OF-POCKET LIMIT

When the amount of combined *covered expenses* paid by *you* satisfy the out-of-pocket limits, including the deductible as shown on the Schedule of Benefits, the *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums and the lifetime maximum of the *Plan*. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.*

Covered expenses are subject to any *calendar year* maximums or the lifetime maximum of the *Plan*.

LIFETIME MAXIMUM

Lifetime maximum means the maximum amount of benefits available while *you* are covered under the *Plan*. Under no circumstances does lifetime mean during the lifetime of the *covered person*.

**Covered expenses* are payable on a *maximum allowable fee* basis. Inpatient Hospital, inpatient *mental disorder*, chemical dependence and alcoholism expenses, Skilled Nursing Facility and Long Term Acute Care Facility expenses and flu and pneumonia vaccinations do not apply to the deductible shown on the Schedule of Benefits. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a:

1. *Hospital* for daily semi-private, ward, intensive care or coronary care room and board charges for each day of *confinement*. The maximum amount payable is shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient;

2. *Hospital* for *services* furnished for *your* treatment during *confinement*.

OUTPATIENT HOSPITAL

Covered expenses are payable as shown on the Schedule of Benefits. *Covered expenses* include charges made by a *hospital* for:

1. Treatment of a *bodily injury*, including the emergency room charge if rendered within 48 hours of an accident;

2. Treatment of a *sickness* following an *emergency*, including the emergency room charge;

3. *Preadmission testing*;

4. A surgical procedure;

5. Regularly scheduled treatment such as chemotherapy, inhalation therapy, radiation therapy as ordered by *your* attending physician.

FREE-STANDING SURGICAL FACILITY

Charges made by a *free-standing surgical facility*, for surgical procedures performed and for *services* rendered in the facility are payable as shown on the Schedule of Benefits.

URGENT CARE CENTER

Facility charges made by an urgent care center are payable as shown on the Schedule of Benefits. Outpatient *surgery*, diagnostic x-ray, laboratory tests and any additional *services* other than the facility charge are not payable under this benefit. Please refer to the other provisions of this *Plan* for available coverage.

QUALIFIED PRACTITIONER

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a *qualified practitioner* when incurred for:

1. Office, home, *emergency* room physician or inpatient *hospital* visits;

2. Diagnostic x-ray or laboratory tests;

Qualified Practitioner Continued

3. Professional *services* of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy;

4. Other covered medical *services* received from or at the direction of a *qualified practitioner*;

5. Administration of anesthesia;

6. A surgical procedure, including pre-operative and post-operative care.

   If multiple surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary procedure and 50% of the *maximum allowable fee* for subsequent procedures when performed independently.

   No benefits will be payable for incidental procedures.

7. Assisting the surgeon;

8. Physician assistant;

9. Charges made by a *qualified practitioner* for *services* in performing certain oral surgical operations due to *bodily injury* or *sickness* are covered as with *Medicare*. *Medicare* covers dental *services* that are part of a covered procedure (reconstruction of the jaw following an accidental injury) or for extracts done in preparation for a radiation treatment for neoplastic diseases involving the jaw.

ROUTINE CARE

The following expenses are payable for *you*, as on the Schedule of Benefits, subject to all terms and provisions of the *Plan*, except the exclusion for *services* which are not *medically necessary*, if *you* are not confined in a *hospital* or *qualified treatment facility* and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness.*

Benefits include:

1. Routine examinations, Internal Medicine, Pediatrician, General & Family Practice only;

2. Routine x-ray and laboratory tests;

3. Mammograms;

4. Pap smears, only applies to labs associated with the office visit;

5. Flu/pneumonia immunizations;

6. Routine immunizations;

7. Internal Medicine, Pediatrician, General & Family Practice only;

8. Prostate antigen testing;

Routine Care Continued

9. Routine cancer screenings (colonoscopy, sigmoidoscopy and proctosigmoidoscopy).

No benefits are payable under this benefit for:

1. Any dental examinations;

2. Hearing examinations;

3. Medical examination for *bodily injury* or *sickness*;

4. Medical examination caused by or resulting from pregnancy. Pregnancy is not considered routine.

CHIROPRACTIC CARE

Chiropractic care for treatment of a *bodily injury* or *sickness* is payable as shown on the Schedule of Benefits, *when medically necessary*. *Maintenance care* is not covered.

AMBULANCE SERVICE

Local professional ambulance service to the nearest *hospital* equipped to provide the necessary treatment is covered as shown on the Schedule of Benefits. Ambulance service must not be provided primarily for the convenience of the patient or the *qualified practitioner*.

PREGNANCY BENEFITS

Pregnancy is a *covered expense* for any *covered person* payable as shown on the Schedule of Benefits.

Complications of pregnancy are payable as any other covered *sickness* at the point the complication sets in for any *covered person*.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORNS' ACT)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's attending provider, after consulting with the mother, from discharging the mother earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the *Plan* or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SKILLED NURSING FACILITY

Covered expenses for a skilled nursing facility *confinement* are payable when the *confinement*:

1. Begins while *you* are covered under this *Plan*;

2. Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;

3. Is necessary for care or treatment of the same *bodily injury* or *sickness* which caused the prior *confinement*; and

4. Occurs while *you* are under the regular care of the physician.

Skilled nursing facility means only an institution licensed as a skilled nursing facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;

2. A physician's *services* available at all times;

3. 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);

4. A daily record for each patient;

5. Continuous skilled nursing care for sick or injured persons during their convalescence from *sickness* or *bodily injury*; and

6. A utilization review plan.

A skilled nursing facility is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental disorders*, chemical dependence or alcoholism.

BENEFITS PAYABLE

Expense incurred for daily room and board and general nursing *services* for each day of *confinement* in a skilled nursing facility is payable as shown on the Schedule of Benefits. The daily rate will not exceed the maximum daily rate established for licensed skilled nursing care facilities by the Department of Health and Social Services.

HOME HEALTH CARE

Expense incurred for home health care as described below is payable as shown on the Schedule of Benefits.

Each visit by a home health care provider for evaluating the need for, developing a plan, or providing *services* under a home health care plan will be considered one home health care visit. Up to 4 consecutive hours of service in a 24-hour period is considered one home health care visit. A visit by a home health care provider of 4 hours or more is considered one visit for every 4 hours or part thereof.

Home health care provider means an agency licensed by the proper authority as a home health agency or *Medicare* approved as a home health agency.

Home health care will not be reimbursed unless the *Plan* determines:

1. Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;

2. Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and

3. The home health care *services* will be provided or coordinated by a state-licensed or *Medicare*-certified home health agency or certified rehabilitation agency.

The home health care plan must be reviewed and approved by the *qualified practitioner* under whose care *you* are currently receiving treatment for the *bodily injury* or *sickness* which requires the home health care.

The home health care plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.);

2. Physical, speech, occupational and respiratory therapy and home health aide *services*; and

3. Medical supplies and *durable medical equipment*, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital* confined.

LIMITATIONS ON HOME HEALTH CARE BENEFITS

Home health care benefits do not include:

1. Charges for mileage or travel time to and from the *covered person's* home;

2. Wage or shift differentials for home health care providers; or

3. Charges for supervision of home health care providers.

HOSPICE CARE

Hospice *services* must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of six months or less.

> For hospice *services* only, *your* immediate family is considered to be *your* parent, spouse, and *your* children or step-children.

Covered expenses are payable as shown on the Schedule of Benefits for the following hospice *services*:

1. Room and board and other *services* and supplies;

2. Part-time nursing care by or supervised by a R.N. for up to 8 hours per day;

3. Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;

4. Medical social *services* provided to *you* or *your* immediate family under the direction of a *qualified practitioner,* which include the following:

    a. Assessment of social, emotional and medical needs, and the home and family situation,

    b. Identification of the community resources available, and

    c. Assistance in obtaining those resources;

5. Nutritional counseling;

6. Physical or occupational therapy;

7. Part-time home health aide service for up to 8 hours in any one day; and

8. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

LIMITATIONS ON HOSPICE CARE BENEFITS

Hospice care benefits do NOT include: (1) private duty nursing *services* when confined in a hospice facility; (2) a *confinement* not required for pain control or other acute chronic symptom management; (3) funeral arrangements; (4) financial or legal counseling, including estate planning or drafting of a will; (5) homemaker or caretaker *services*, including a sitter or companion *services*; (6) housecleaning and household maintenance; (7) *services* of a social worker other than a licensed clinical social worker; (8) *services* by volunteers or persons who do not regularly charge for their *services*; or (9) *services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

Hospice care program means a written plan of hospice care, established and reviewed by the *qualified practitioner* attending the patient and the hospice care agency, for providing palliative and supportive care to hospice patients. It offers supportive care to the families of hospice patients, an assessment of the hospice patient's medical and social needs, and a description of the care to meet those needs.

Hospice Care Continued

Hospice facility means a licensed facility or part of a facility which principally provides hospice care, keeps medical records of each patient, has an ongoing quality assurance program and has a physician on call at all times.

A hospice facility provides 24-hour-a-day nursing *services* under the direction of a R.N. and has a full-time administrator.

Hospice care agency means an agency which has the primary purpose of providing hospice *services* to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meets all of these requirements: (1) has obtained any required certificate of need; (2) provides 24-hours a day, 7 day-a-week service supervised by a *qualified practitioner*; (3) has a full-time coordinator; (4) keeps written records of *services* provided to each patient; (5) has a nurse coordinator who is a R.N., who has four years of full-time clinical experience, of which at least two involved caring for terminally ill patients; and, (6) has a licensed social service coordinator.

A hospice care agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its *services* for their patients, and use volunteers trained in care of and *services* for non-medical needs.

ORGAN TRANSPLANT BENEFIT

The *Plan* will pay benefits for the expense of a transplant as defined below for a *covered person* when approved in advance by *Medicare*, subject to those terms, conditions and limitations described below and contained in the *Plan*.

COVERED ORGAN TRANSPLANT

Only the *services*, care and treatment received for, or in connection with transplant of the organs identified hereafter, which are determined by *Medicare* to be *medically necessary services* and which are not *experimental, investigational or for research purposes* will be covered by the *Plan*. The transplant includes: pre-transplant *services*, transplant inclusive of any chemotherapy and associated *services*, post-discharge *services* and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;
2. Lung(s);
3. Heart-lung;
4. Liver;
5. Kidney;
6. Bone Marrow*;
7. Intestine;
8. Simultaneous pancreas/kidney;
9. Pancreas following kidney;
10. Any organ not listed above required by federal law and Medicare.

Organ Transplant Benefit Continued

*The term bone marrow refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by *Medicare*.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the *Plan*.

For a transplant to be considered fully approved, prior written approval from the Plan Manager is required in advance of the transplant. *You* or *your qualified practitioner* must notify the Plan Manager in advance of *your* need for an initial transplant evaluation in order for the Plan Manager to determine if the transplant will be covered. For approval of the transplant itself, the Plan Manager must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Once the transplant is approved, the Plan Manager will advise the *covered person's qualified practitioner*. Benefits are payable only if the pre-transplant *services*, the transplant and post-discharge *services* are approved by the Plan Manager.

EXCLUSIONS

No benefit is payable for, or in connection with, a transplant if not covered by *Medicare*:

1. It is *experimental, investigational or for research purposes* as defined in the Definitions section of this booklet.

2. The Plan Manager is not contacted for authorization prior to referral for evaluation of the transplant, unless such authorization is waived by the Plan Manager.

3. The Plan Manager does not approve coverage for the transplant, based on its established criteria.

4. Expenses are eligible to be paid under any private or public research fund, government program, except Medicaid, or another funding program, whether or not such funding was applied for or received.

5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *Plan*.

6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the *Plan*.

Organ Transplant Benefit Continued

7. A denied transplant is performed; this includes the pre-transplant evaluation, pre-transplant *services*, the transplant procedure, post-discharge *services*, immunosuppressive drugs and complications of such transplant.

8. The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by the Plan Manager.

COVERED SERVICES

For approved transplants, and all related complications, the *Plan* will cover only the following expenses:

1. *Hospital* and *qualified practitioner* benefits, payable as shown on the Schedule of Benefits.

2. Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under the *Plan* if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person*, except the reasonable costs of searching for the donor may be limited to the immediate *family members* and the National Bone Marrow Donor Program.

3. Direct, non-medical costs* for the *covered person* will be paid for: (a) transportation to and from the *hospital* where the transplant is performed; and (b) temporary lodging at a prearranged location up to $75 per day when requested by the *hospital* and approved by *Medicare*. Transportation costs for the *covered person* to and from the *hospital* where the transplant is performed will be payable as shown on the Schedule of Benefits. These direct, non-medical costs are only available if the *covered person* lives more than 100 miles from the transplant facility.

4. Direct, non-medical costs* for one member of the *covered person's* immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the transplant is performed; and (b) temporary lodging at a prearranged location up to $75 per day during the *covered person's confinement* in the *hospital*. Transportation costs for the *covered person's* immediate *family member(s)* to and from the *hospital* where the transplant is performed will be payable as shown on the Schedule of Benefits. These direct, non-medical costs are only available if the *covered person's* immediate *family member(s)* live more than 100 miles from the transplant facility.

   *All direct, non-medical expenses for the *covered person* receiving the transplant and his/her *family member(s)* are limited to a combined *maximum benefit* of $10,000 per transplant.

MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFIT

Expense incurred by *you* during a plan of treatment for *mental disorder*, chemical dependence or alcoholism is payable for:

1. Charges made by a *qualified practitioner*;

2. Charges made by a *hospital*;

3. Charges made by a *qualified treatment facility*;

INPATIENT BENEFITS

Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility* or residential treatment facility, are payable at 100% after $250 *copayment* per admission. Inpatient treatment of a *mental disorder*, chemical dependence or alcoholism is limited to a maximum of 190-day lifetime limit in a psychiatric *hospital.*

Covered expenses for inpatient treatment aggregate toward the out-of-pocket limits described on the Schedule of Benefits.

OUTPATIENT BENEFITS

Covered expenses for outpatient treatment and treatment at a residential treatment facility received while not confined in a *hospital* or *qualified treatment facility* are subject to deductible, then payable at 90%.

Covered expenses for outpatient treatment aggregate toward the out-of-pocket limits described on the Schedule of Benefits.

PARTIAL HOSPITALIZATION

Covered expenses received for partial hospitalization arrangements are subject to deductible, then payable at 90%.

Covered expenses for partial hospitalization treatment aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

LIMITATIONS ON MENTAL DISORDER, CHEMICAL DEPENDENCE OR ALCOHOLISM BENEFITS

No benefits are payable under this provision for marriage counseling, treatment of nicotine habit or addiction, or for treatment of being obese or overweight.

Treatment must be provided for the cause for which benefits are payable under this provision of the *Plan*.

OTHER COVERED EXPENSES

The following are other *covered expenses* payable as shown on the Schedule of Benefits:

1. Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;

2. Oxygen and rental of equipment for its administration;

3. Drugs and medicines that are provided to, or administered to, *you* while *you* are confined in a *hospital* or skilled nursing facility, or from a *qualified practitioner* during an office visit or from a home health care provider;

4. Drugs and medicines required by law to be obtained on the written prescription of a *qualified practitioner* when not rendered by a *pharmacy*;

5. Initial prosthetic devices or supplies, including but not limited to, limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. *Covered expense* includes repair of the prosthetic device if not covered by the manufacturer;

6. Supplies, up to a 30-day supply, when prescribed by *your* attending physician;

7. Casts, trusses, crutches, splints except for dental splints, and braces except for orthodontic braces;

8. Initial contact lenses or eyeglasses following cataract *surgery*;

9. The rental, up to but not to exceed the purchase price, of a wheelchair, hospital bed, ventilator, hospital type equipment or other *durable medical equipment (DME)*. The *Plan*, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Repair, maintenance or duplicate *DME* rental is not considered a *covered expense*;

10. Orthotics that are custom made or custom fitted, made of rigid or semi-rigid material. Replacement orthotics are not a *covered expense*;

11. *Advanced imaging service*;

12. Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment or supplies in the treatment of diabetes;

13. Surgical or non-surgical treatment including but not limited to, appliances and therapy, for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull. Surgical or non-surgical treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches. These expenses do not include charges for orthodontic *services*;

Other Covered Expenses Continued

14. Reconstructive *services* following a covered mastectomy, including but not limited to:
    a. reconstruction of the breast on which the mastectomy was performed;
    b. reconstruction of the other breast to achieve symmetry;
    c. prosthesis; and
    d. treatment of physical complications of all stages of the mastectomy, including lymphedemas;

15. Speech, occupational and physical therapy;

16. Respiratory therapy;

17. Cardiac rehabilitation, limited to phases I and II;

18. Chemotherapy and radiation therapy;

19. Osteotomies;

20. Surgical *services* for *morbid obesity*, only when *medically necessary* as covered by *Medicare*;

21. Nuclear Medicine;

22. Hearing Therapy;

23. Renal dialysis;

24. Comprehensive outpatient rehabilitation facility;

25. Rural health clinic and *hospital* based clinics;

26. Podiatry *services*, when *medically* necessary, which includes treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) and routine foot care for members with certain medical conditions affecting the lower limbs;

27. Free-standing dialysis center;

28. Free-standing radiology center;

29. Allergy injections, testing and vials;

30. Injections (other than routine);

31. Health education and referral services (*services* may be subject to hospital or outpatient copayment).

LIMITATIONS AND EXCLUSIONS

The *Plan* does not provide benefits for:

1. *Services*:
   a. Not furnished by a *qualified practitioner* or *qualified treatment facility*;
   b. Not authorized or prescribed by a *qualified practitioner*;
   c. Not covered by this *Plan* whether or not prescribed by a *qualified practitioner*;
   d. Which are not provided;
   e. For which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this *Plan* unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or
   f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or Medicaid);
   g. Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
   h. Performed in association with a *service* that is not covered under this *Plan*;
   i. Performed as a result of a complication arising from a *service* that is not covered under this *Plan*.

2. Routine vision examinations or testing; *services* to correct eye refractive disorders; radial keratotomy, refractive keratoplasty or any other *surgery* to correct myopia, hyperopia or stigmatic error; or, the purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this *Plan*;

3. Vision therapy (eye exercises to strengthen the muscles of the eye);

4. Routine hearing examinations;

5. Hearing aids, the fitting or repair of hearing aids or advice on their care; implantable hearing devices;

6. Routine physical examinations and related *services* for occupation, employment, school, sports, camp, travel, purchase of insurance or premarital tests or examinations, unless specifically provided under this *Plan*;

7. Immunizations required for foreign travel;

8. All fertility testing or *services* (other than diagnostic testing or services), including any artificial means to achieve pregnancy or ovulation, such as artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;

Limitations and Exclusions Continued

9. *Services* related to gender change;

10. *Services* for a reversal of sterilization;

11. Cosmetic *surgery* and cosmetic *services* or devices, unless for reconstructive *surgery*:
    a. Resulting from a *bodily injury*, infection or other disease of the involved part, when functional impairment is present; or
    b. A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. *Expense incurred* for reconstructive *surgery* performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met;

12. Hair prosthesis, hair transplants or hair implants;

13. Wigs;

14. Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, routine dental extractions and orthodontic procedures, unless specifically provided under this *Plan*;

15. Dental osteotomies;

16. *Services* which are:
    a. Rendered in connection with a *mental disorder* not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation;

    Marriage counseling is specifically excluded;

17. Court ordered *mental disorder*, chemical dependence or alcoholism *services*;

18. Education or training, except for diabetes self-management training;

19. Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded;

Limitations and Exclusions Continued

20. Expenses for *services* that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *qualified practitioner*) and certain medical devices including, but not limited to:
    a. Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
    b. Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
    e. Medical equipment including blood pressure monitoring devices, breast pumps, PUVA lights and stethoscopes;
    f. Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
    g. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx;

21. Any medical treatment, procedure, drug, biological product or device which is *experimental, investigational or for research purposes*, unless otherwise specified in the *Plan*;

22. *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;

23. Charges in excess of the *maximum allowable fee* for the *service*;

24. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;

25. Any *expense incurred* prior to *your* effective date under the *Plan* or after the date *your* coverage under the *Plan* terminates, except as specifically described in this *Plan*;

26. *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical plan;

27. Any expense due to the *covered person's*:
    a. Engaging in an illegal occupation; or
    b. Commission of or an attempt to commit a criminal act;

28. Any loss caused by or contributed to:
    a. War or any act of war, whether declared or not;
    b. Insurrection; or
    c. Any act of armed conflict, or any conflict involving armed forces of any authority;

29. *Emergency* care is covered the same as any other benefit within the United States at 4% coinsurance and it will apply to the $1,200 maximum out-of-pocket. Inpatient copayments apply. Non-*emergency* care is covered at 20% coinsurance and does not apply to the $1,200 maximum out-of-pocket. A maximum allowable benefit of $5,000 applies for non-*emergency* care ;

Limitations and Exclusions Continued

30. Birth control pills, devices, injections, implant systems and the removal of implant systems;

31. Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products, classes or tapes;

32. Vitamins, dietary supplements and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU);

33. Over the counter, non-prescription medications;

34. Medication, drugs or hormones to stimulate growth unless there is a laboratory confirmed diagnosis of growth hormone deficiency, as determined by the *Plan*;

35. Therapy and testing for treatment of allergies including, but not limited to, *services* related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:
    a. The American Academy of Allergy and Immunology, or
    b. The Department of Health and Human Services or any of its offices or agencies;

36. Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:
    a. The *services* do not require a professional interpretation, or
    b. The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*;

37. *Services* related to the treatment and/or diagnosis of sexual dysfunction/impotence;

38. Any treatment, including but not limited to, surgical procedures:
    a. For obesity, other than *morbid obesity*;
    b. For obesity, other than *morbid obesity*, for the purpose of treating a *sickness* or *bodily injury* caused by, complicated by, or exacerbated by the obesity;

39. Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs;

40. *Alternative medicine*;

41. Acupuncture;

42. *Services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;

43. Services of a midwife, unless provided by a Certified Nurse Midwife;

Limitations and Exclusions Continued

44. Chiropractic care, when not *medically necessary* and when performed by a Primary Care Physician;

45. The following types of care of the feet:
    a. Shock wave therapy of the feet;
    b. The treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
    e. The cutting of toenails, except the removal of the nail matrix;
    f. The provision of heel wedges, lifts or shoe inserts; and
    g. The provision of arch supports or orthopedic shoes, unless *medically necessary* because of diabetes or hammertoe;

46. *Custodial care* and *maintenance care*;

47. *Hospital* inpatient *services* when *you* are in observation status;

48. *Services* rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless *medically necessary*;

49. Private duty nursing;

50. Ambulance *services* for routine transportation to, from or between medical facilities and/or a *qualified practitioner's* office;

51. *Preadmission*/procedural testing duplicated during a *hospital confinement*;

52. Lodging accommodations or transportation, unless specifically provided under this *Plan*;

53. Communications or travel time;

54. No benefits will be provided for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis;
    c. Biliary lithotripsy;
    d. Home uterine activity monitoring;
    e. Sleep therapy;
    f. Light treatments for Seasonal Affective Disorder (S.A.D.);
    g. Immunotherapy for food allergy;
    h. Prolotherapy;
    i. Cranial banding;
    j. Hyperhydroosis *surgery*;
    k. Lactation therapy; or
    l. Sensory integration therapy;

Limitations and Exclusions Continued

55. *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverages under this *Plan* did not exist;

56. Any *covered expenses* to the extent of any amount received from others for the *bodily injuries* or losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

NOTE: These limitations and exclusions apply even if a *qualified practitioner* has performed or prescribed a *medically necessary* procedure, treatment or supply. This does not prevent *your qualified practitioner* from providing or performing the procedure, treatment or supply, however, the procedure, treatment or supply will not be a *covered expense*.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

Once annually *you* will have a choice of enrolling *yourself* in this *Plan* without experiencing a qualifying event. *You* will be notified in advance by newsletter when the open enrollment period is to begin and how long it will last. If *you* decline coverage for yourself at the time *you* are initially eligible for coverage, *you* will be able to enroll yourself during the Open Enrollment Period.

ELIGIBILITY

You are eligible for coverage if *you* are a *covered person* who meets the eligibility requirements of the *Plan Sponsor*. In most cases, *your* effective date is the first of the month following receipt of *your* completed enrollment.

CREDITABLE COVERAGE

Once *you* obtain health plan coverage, *you* are entitled to use evidence of that coverage to reduce or eliminate any pre-existing condition limitation period that might otherwise be imposed when *you* become covered under a subsequent health plan. Evidence may include a certificate of prior *creditable coverage*. The length of any pre-existing condition limitation period under the subsequent health plan must be reduced by the number of days of *creditable coverage*.

This *Plan* has no pre-existing conditions.

SPECIAL ENROLLMENT

If *you* are declining coverage for yourself or *your* eligible spouse because of other health insurance or group health plan coverage, *you* may be able to enroll *yourself* and *your* eligible spouse in this *Plan* if *you* or *your* eligible spouse loses eligibility for that other coverage (or if the *Plan Sponsor* stops contributing towards *your* or *your* eligible spouse's other coverage). However, *you* must request enrollment within 30 days after *your* or *your* eligible spouse's other coverage ends (or after the *Plan Sponsor* stops contributing towards the other coverage).

To request special enrollment or obtain more information, contact the KTRS Insurance Department at 502-848-8500 or toll free at 1-800-618-1687.

RETIREE ELIGIBILITY

You are in an eligible class if *you* are a retiree who is entitled to *Medicare*. Upon retirement, if *you* are then in an eligible class, *your* eligibility date is the month following the effective date of *your* retirement.

DEPENDANT ELIGIBILITY

A covered retiree may cover their spouse who is entitled to *Medicare*. However, coverage in the KTRS Plan is through the retired member, which requires the retiree to be enrolled for the spouse to be eligible. Upon the death of a retiree, the retiree's spouse will have 30 days from the date of death to elect coverage or permanently decline coverage. Spouses of deceased retirees will terminate their coverage in the event of remarriage. With the exception of adult handicapped children, children of retirees are not eligible for this *Plan*.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the *Plan* terminates;

2. The end of the period for which any required contribution was due and not paid;

3. The date *you* fail to be in an eligible class of persons according to the eligibility requirements of the *Plan Sponsor*;

4. For any benefit, the date the benefit is removed from the *Plan*;

5. The first day of the month following receipt of *your* written request of termination.

IF *YOU* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* AND THE *PLAN SPONSOR* ARE RESPONSIBLE FOR NOTIFYING THE *PLAN MANAGER* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF NOTICE HAS NOT BEEN GIVEN TO THE *PLAN MANAGER.*

HOW AND WHEN WILL COVERAGE TERMINATE?

Retiree coverage will terminate:

- Upon KTRS' receipt of written notice of desire to cancel *Plan* coverage.
- When *you* are no longer in an eligible class.
- Upon failure to make a required contribution.

Spouse coverage will terminate:

- Upon KTRS' receipt of written notice of desire to cancel *Plan* coverage.
- Upon divorce thus making spouse no longer eligible (spouse may be eligible to continue coverage through COBRA for a limited time period).
- When spouse becomes eligible for this *Plan* under own KTRS retirement.
- Upon failure to make a required contribution.
- Upon remarriage by a spouse of deceased retiree thus making spouse no longer eligible.
- Upon spouse's or retiree's ineligibility.

HIPAA Portability Member Notice

When a *covered person's* coverage ends, the *Plan Sponsor* or *Plan Manager* will mail a Certificate of Coverage to the *covered person* within 30 days of the coverage termination date; however, a *covered person* may request a Certificate of Coverage at any time by contacting:

KTRS Call Center or Insurance Division
479 Versailles Road
Frankfort, KY 40601
502-848-8500
1-800-618-1687 (Toll Free)

CONTINUATION COVERAGE RIGHTS UNDER COBRA-GENERAL NOTICE

Introduction
This notice applies if *you* are enrolling or have enrolled under the Kentucky Teachers' Retirement System (KTRS) Health Plan (the *Plan*). This notice contains important information about *your* right to COBRA continuation coverage, which is a temporary extension of coverage under the *Plan*. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to *you* and eligible dependants that are covered under the *Plan* when *you* would otherwise lose *your* group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to *you* and *your* eligible dependants, and what *you* need to do to protect the right to receive it.** This notice gives only a summary of *your* COBRA continuation coverage rights. For more information about *your* rights and obligations under the *Plan* and under federal law, *you* should review the *Plan's* Summary Plan Description or contact the KTRS Insurance Division.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of *Plan* coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified COBRA beneficiary." A qualified COBRA beneficiary is someone who will lose coverage under the *Plan* because of a qualifying event. Depending on the type of qualifying event, retirees and their eligible dependants may be qualified beneficiaries. Under the *Plan*, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If *you* are a retiree, *you* will become a qualified COBRA beneficiary if *you* lose *your* coverage under the *Plan* because one of the following qualifying events happens:

- *Your* retirement ends; or
- *You* lose eligibility due to re-employment.

If *you* are an eligible dependant of a retiree, *you* will become a qualified COBRA beneficiary if *you* lose *your* coverage under the *Plan* because any of the following qualifying events happens:

- The retiree's retirement ends;
- The retiree loses eligibility due to re-employment;
- The retiree or covered spouse both become enrolled in *Medicare*;
- The retiree becomes divorced;
- The retiree or covered parent-surviving spouse dies; or
- Eligible dependant becomes no longer eligible or no longer dependant.

When is COBRA coverage available?
The *Plan* will offer COBRA continuation coverage to qualified beneficiaries only after the KTRS Insurance Division has been notified that a qualifying event has occurred.

***You* Must Give Notice of the Qualifying Event**
For any qualifying event, *you* must notify the KTRS Insurance Division within 60 days following the date coverage ends with the exception of divorce or loss of eligible dependency which is 60 days following the date of event.

COBRA Continued

How is COBRA coverage provided?

Upon the KTRS Insurance Division's receipt of a timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Covered retirees may elect COBRA continuation coverage on behalf of their covered eligible spouses, and eligible covered parents may elect COBRA continuation coverage on behalf of their eligible covered dependants. For each qualified COBRA beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that *Plan* coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage that may last for up to 36 months with the exception of retirement and re-employment related qualifying events, which generally may last up to 18 months.

When COBRA continuation coverage lasts for up to 18 months, there are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If *you* or an eligible dependant covered under the *Plan* is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, and *you* notify the KTRS Insurance Division in a timely fashion, *you* and *your* eligible dependants may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If *you* and *your* eligible dependants experience another qualifying event while receiving 18 months of COBRA continuation coverage, there may be additional months of COBRA continuation coverage available to *your* eligible dependants, up to a maximum of 36 months. **In all of these cases, *you* must make sure that the KTRS Insurance Division is notified of the second qualifying event within 60 days of the second qualifying event.**

If *You* Have Questions

If *you* have questions about *your* COBRA continuation coverage, *you* should contact the KTRS Insurance Division or *you* may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep *Your Plan* Informed of Address Changes

In order to protect *your* rights and the rights of *your* eligible covered dependants, *you* should keep the KTRS Insurance Division informed of any changes in address. *You* should also keep a copy, for *your* records, of any notices *you* send to the KTRS Insurance Division.

Plan Contact for Further Information

Kentucky Teachers' Retirement System Health Plan
Insurance Division
479 Versailles Road
Frankfort, KY 40601
502-848-8500
800-618-1687

COBRA Continued

If you experience a COBRA qualifying event, then you will receive the following additional information and notice on electing COBRA:

COBRA CONTINUATION COVERAGE
ELECTION NOTICE-Action Required

[Enter date of notice]

Dear: *[Identify the qualified COBRA beneficiary(ies), by name or **status]***

This notice contains important information about your right to continue your health care coverage in the *[enter name of group health plan, KTRS Medicare Eligible Health Plan]* (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to the KTRS Insurance Division.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on *[enter date]* due to *[check appropriate box]:*

- The retiree's retirement ends;
- The retiree loses eligibility due to re-employment;
- The retiree or covered spouse both become enrolled in Medicare;
- The retiree becomes divorced;
- The retiree or covered parent-surviving spouse dies; or
- Eligible dependant becomes no longer eligible or no longer dependant.

Each person ("qualified COBRA beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to __ months *[enter* 18 *or* 36*, as appropriate and check appropriate box or boxes; names may be added]:*

- Retiree or former retiree
- Eligible Covered Spouse or Covered Surviving Spouse
- Eligible Dependant Adult Handicapped child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Adult Handicapped Child who is losing coverage under the Plan because he or she is no longer a dependant or no longer eligible under the Plan

If elected, COBRA continuation coverage will begin on *[enter date]* and can last until *[enter date].*

COBRA continuation coverage will cost $_____ per month for plan year 20_ _. *[enter amount each qualified COBRA beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]* Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact The KTRS Insurance Division, ATTN COBRA Election, 479 Versailles Road, Frankfort KY 40601 at 502-848-8500 or 1-800-618-1687.

COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to the KTRS Insurance Division. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: The KTRS Insurance Division, ATTN COBRA Election, 479 Versailles Road, Frankfort KY 40601

This Election Form must be completed, signed, and returned by mail. It must be post-marked no later than *[enter date]*.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the *[enter name of plan, KTRS Medicare Eligible Health Plan]* (the Plan) as indicated below:

	Name	Date of Birth	Relationship to Retiree	SSN (or other identifier)
a.				
b.				
c.				

Signature	**Date**
Print Name	**Relationship to individual(s) listed above**
Print Address	**Telephone Number**

Above form must be completed in its entirety!

Warning: **Do Not Proceed without following all payment instructions on page three.**

COBRA Continued

When and how must payment for COBRA continuation coverage be made? First payment for continuation coverage

If you elect continuation coverage, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is completed and signed by you and post-marked.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the KTRS Insurance Division to confirm the correct amount of your first payment.

Remaining monthly payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent coverage period. The amount due for each coverage period for each qualified COBRA beneficiary is shown in this notice. The periodic payments must be made on a monthly basis not later than the first day of each following month. If you make a monthly payment on or before the first day of the following month, your coverage under the Plan will continue for that month without any break. It is your responsibility to make timely monthly payments regardless of whether or not the plan sends monthly notices of payments due.

Grace periods for monthly payments

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all monthly payments for continuation coverage should be sent to:

Payments:	**Check Payable to:**	**Amount of Check:**	**Mail to:**	**Include:**
First Payment	**_____**	**$_____ for _____ months**	**The KTRS Insurance Division ATTN COBRA Election 479 Versailles Road Frankfort KY 40601**	**Social Security Number of the retiree on the check and include a copy of this election form and notice**
Remaining Monthly Payments for Calendar Year 20_ _	**_____**	**$_____**	**ATTN _____ _____ _____ _____**	**Social Security Number of the retiree on the check**

COBRA Continued

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this *Plan*) give retirees and their eligible dependants the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under this plan. Depending on the type of qualifying event, "qualified COBRA beneficiaries" can include the retiree covered under the group health plan and the covered eligible dependants of the retiree.

Continuation coverage is the same coverage that the *Plan* gives to other participants or beneficiaries under the *Plan* who are not receiving continuation coverage. Each qualified COBRA beneficiary who elects continuation coverage will have the same rights under the *Plan* as other participants or beneficiaries covered under the *Plan*, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of retirement or loss of eligibility due to re-employment of retiree, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to a retiree's death, divorce or legal separation, becoming entitled to *Medicare* benefits or a dependant adult handicapped child ceasing to be a dependant under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of retirement or loss of eligibility due to re-employment of retiree, and the retiree became entitled to *Medicare* benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified COBRA beneficiaries other than the retiree lasts until 36 months after the date of *Medicare* entitlement. This notice shows the maximum period of continuation coverage available to the qualified COBRA beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified COBRA beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified COBRA beneficiary,
- a qualified COBRA beneficiary becomes entitled to *Medicare* benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Kentucky Teachers' Retirement System ceases to provide any group health plan for its retirees.

Continuation coverage may also be terminated for any reason the *Plan* would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can *you* extend the length of COBRA continuation coverage if *you* have 18 months of COBRA continuation coverage granted?

If *you* elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified COBRA beneficiary is disabled or a second qualifying event occurs. *You* must notify the KTRS Insurance Division of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

COBRA Continued

Disability

An 11-month extension of coverage may be available if any of the qualified COBRA beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The KTRS Insurance Division will need a copy of the SSA disability determination notice. Each qualified COBRA beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified COBRA beneficiary is determined by SSA to no longer be disabled, *you* must notify the *Plan* of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to eligible covered dependants who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of the retiree, divorce or separation from the retiree, the covered retiree's becoming entitled to *Medicare* benefits (under Part A, Part B, or both), or a dependant adult handicapped child's ceasing to be eligible for coverage as a dependant under the *Plan*. These events can be a second qualifying event only if they would have caused the qualified COBRA beneficiary to lose coverage under the *Plan* if the first qualifying event had not occurred. *You* must notify the *Plan* within 60 days after a second qualifying event occurs if *you* want to extend *your* continuation coverage.

How can *you* elect COBRA continuation coverage?

To elect continuation coverage, *you* must complete the Election Form and furnish it according to the directions on the form. Each qualified COBRA beneficiary has a separate right to elect continuation coverage. For example, the retiree's eligible covered spouse may elect continuation coverage even if the retiree does not. Continuation coverage may be elected for only one, several, or for all eligible covered dependant adult handicapped children who are qualified COBRA beneficiaries. A parent may elect to continue coverage on behalf of any dependant adult handicapped children. The retiree or the retiree's eligible covered spouse can elect continuation coverage on behalf of all of the qualified COBRA beneficiaries.

Important Considerations in Electing COBRA Coverage

In considering whether to elect continuation coverage, *you* should take into account that a failure to continue *your* group health coverage will affect *your* future rights under federal law. First, *you* can lose the right to avoid having pre-existing condition exclusions applied to *you* by other group health plans if *you* have more than a 63-day gap in health coverage, and election of continuation coverage may help *you* prevent such a gap. Second, *you* will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if *you* do not get continuation coverage for the maximum time available to *you*. Finally, *you* should take into account that *you* have special enrollment rights under federal law. *You* have the right to request special enrollment in another group health plan for which *you* are otherwise eligible (such as a plan sponsored by *your* spouse's employer) within 30 days after *your* group health coverage ends because of the qualifying event listed above. *You* will also have the same special enrollment right at the end of continuation coverage if *you* get continuation coverage for the maximum time available to *you*.

COBRA Continued

How much does COBRA continuation coverage cost?

Each qualified COBRA beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified COBRA beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including the KTRS, the Commonwealth of KY, and the retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

For more information

If *you* have any questions concerning the information in this notice, *your* rights to coverage, or if *you* want a copy of *your* summary plan description, *you* should contact:

Kentucky Teachers' Retirement System Health Plan Insurance Division
479 Versailles Road
Frankfort KY 40601
Phone: 502-848-8500
Toll Free: 800-618-1687

For more information about *your* rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in *your* area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep *Your* Plan Informed of Address Changes

In order to protect *your* rights and the rights of *your* eligible covered dependants, *you* should keep the KTRS Insurance Division and the carrier informed of any changes in address. *You* should also keep a copy, for *your* records, of any notices *you* send to the KTRS Insurance Division.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this *Plan* are coordinated with benefits provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical coverage.

For this purpose, a plan is one which covers medical expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the *covered person's* membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. *Plan* also includes any coverage provided through the following:

1. *Plan Sponsor*, trustee, union, *covered person* benefit, or other association; or

2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution. Allowable expense means any eligible expense, a portion of which is covered under one of the plans covering the person for whom claim is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid.

EFFECT ON BENEFITS

One of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans.

When this *Plan* is the secondary plan, the sum of the benefit payable will not exceed 100% of the total allowable expenses incurred under the *Plan* and any other plans included under this provision.

ORDER OF BENEFIT DETERMINATION

In order to pay claims, it must be determined which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The plan has no coordination of benefits provision;

2. The plan covers the person as a retiree;

Coordination of Benefits Continued

RIGHT OF RECOVERY

The *Plan* reserves the right to recover benefit payments made for an allowable expense under the *Plan* in the amount which exceeds the maximum amount the *Plan* is required to pay under these provisions. This right of recovery applies to the *Plan* against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

The *Plan* alone will determine against whom this right of recovery will be exercised.

REIMBURSEMENT/SUBROGATION

The *beneficiary* agrees that by accepting and in return for the payment of *covered expenses* by the *Plan* in accordance with the terms of this *Plan*:

1. The *Plan* shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *bodily injuries* or losses which necessitated such *covered expenses.* Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

2. The *Plan's* right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.

3. The right to recover amounts from others for the injuries or losses which necessitate *covered expenses* is jointly owned by the *Plan* and the *beneficiary*. The *Plan* is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the *Plan* as prescribed above; the *Plan* has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the *Plan* is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.

4. The *beneficiary* will cooperate with the *Plan* in any effort to recover from others for the *bodily injuries* and losses which necessitate *covered expense* payments by the *Plan*. The *beneficiary* will notify the *Plan* immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the *Plan*. Neither the *Plan* nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the *Plan Manager* and when asked, assist the *Plan Manager* by:

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information and/or records from any provider as requested by the *Plan Manager*;
- Providing information regarding the circumstances of *your sickness* or *bodily injury*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and
- Providing information the *Plan Manager* requests to administer the *Plan*.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a *bodily injury* or *sickness* for which the information is sought, until the necessary information is satisfactorily provided.

Reimbursement/Subrogation Continued

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the *Plan Manager* in order to protect the *Plan's* recovery rights. Cooperation includes promptly notifying the *Plan Manager* that *you* may have a claim, providing the *Plan Manager* relevant information, and signing and delivering such documents as the *Plan Manager* reasonably request to secure the *Plan's* recovery rights. *You* agree to obtain the *Plan's* consent before releasing any party from liability for payment of medical expenses. *You* agree to provide the *Plan Manager* with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your bodily injury* or *sickness* and its treatment.

You will do whatever is necessary to enable the *Plan Manager* to enforce the *Plan's* recovery rights and will do nothing after loss to prejudice the *Plan's* recovery rights.

You agree that *you* will not attempt to avoid the *Plan's* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide the *Plan Manager* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the *Plan's* rights will be a material breach of this *Plan* and will result in the *covered person* being personally responsible to make repayment. In such an event, the *Plan* may deduct from any pending or subsequent claim made under this *Plan* any amounts the *covered person* owes the *Plan* until such time as cooperation is provided and the prejudice ceases.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the *Plan*.

RIGHT TO REQUEST OVERPAYMENTS

The *Plan* reserves the right to recover any payments made by the *Plan* that were:

1. Made in error; or

2. Made to *you* or any party on *your* behalf where the *Plan* determines the payment to *you* or any party is greater than the amount payable under this *Plan*.

The *Plan* has the right to recover against *you* if the *Plan* has paid *you* or any other party on *your* behalf.

WORKERS' COMPENSATION NOT AFFECTED

The *Plan* is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

WORKERS' COMPENSATION

If benefits are paid by the *Plan* and the *Plan* determines *you* received Workers' Compensation for the same incident, the *Plan* has the right to recover as described under the Reimbursement/Subrogation provision. The *Plan* will exercise its right to recover against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier;

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the *Plan*, *you* will notify the *Plan Manager* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the *Plan* as described above.

MEDICAID

This *Plan* will not take into account the fact that a *covered person* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under this *Plan*, payment of benefits under this *Plan* will be made in accordance with a state law which provides that the state has acquired the rights with respect to a *covered person* to the benefits payment (Medicaid is the payor of last resort).

General Provisions Continued

CONSTRUCTION OF PLAN TERMS

The *Plan* has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the *Plan*, including, without limitation, the benefits provided thereunder, the obligations of the *beneficiary* and the recovery rights of the *Plan*; such construction and prescription by the *Plan* shall be final and uncontestable.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If *you* have had or are going to have a mastectomy, *you* may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the covered mastectomy was performed;
- *Surgery* and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Contact *your Plan Sponsor* if *you* would like more information on WHCRA benefits.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this *Plan.*

If *you* would like more information on WHCRA benefits, call *your* Plan Administrator using the phone number on the back of *your* medical card.

PRIVACY NOTICE

Kentucky Teachers' Retirement System (KTRS)*

Notice of Privacy Practices

This notification is being sent you to satisfy requirements of federal laws relating to HIPAA.

No further action is necessary on your part.

We have prepared this notice of our privacy practices for members of our self-insured Medicare Eligible Health Plan (MEHP), and it is being sent to you as required by the Health Insurance Portability and Accountability Act known as HIPAA.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and maintain for future reference.

General Provisions Continued

Personal information is confidential. KTRS protects the privacy of that information in accordance with federal and state privacy laws, as well as our own internal privacy policies. This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information. When we use the term "personal information," we mean financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information" we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care). Please note that others involved in your healthcare such as doctors and pharmacies may send you separate notices describing their privacy practices.

This notice became effective on April 14, 2003.

How KTRS Uses and Discloses Personal Information

We need personal information about you in order to provide you with insurance coverage, which includes health benefits and retail and mail order pharmacy services. In administering the self-funded MEHP along with our third party administrator (TPA) and our pharmaceutical benefits manager (PBM), we may use and disclose personal information in various ways, which are not limited to, but include:

Health Care Operations: We may use and disclose personal information about you during the course of administering our self-funded MEHP - that is, during operational activities such as quality control; performance measurement and outcome assessment; recovery initiatives; cost containment methodologies and assessment; wellness initiatives; data aggregation services; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma, heart failure, gastroesophageal reflux disease or depression. Other operational activities requiring use and disclosure include detection and investigation of fraud; internal or external audits; actuarial studies and valuations; legal services; underwriting and rating; network management; formulary management; and other general administrative activities such as data and information systems management and customer service.

Payment: We may use and disclose personal information in a number of ways to help pay for your covered medical and pharmacy services. Some of these include - conducting utilization and medical necessity reviews; coordinating care; determining eligibility; processing enrollments and terminations; adjudicating or subrogating claims; processing claims; designing and implementing coverage management rules; determining formulary compliance; collecting premiums; calculating cost sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be - and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the primary insured). In securing payment from appropriate parties, we may coordinate benefits with Medicare or other payors. In addition, our third party administrator and pharmaceutical benefits manager make claims information available to the subscriber and all covered dependants through their respective websites and via telephonic claims status sites.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may send certain information to doctors for patient safety or other treatment-related decisions.

General Provisions Continued

Additional Reasons for Disclosure: We may use or disclose health information about you in providing you or your physicians or pharmacists with treatment alternatives or reminders, preferred therapies, patient safety alerts, potential drug interactions, formulary alternatives, or other health-related benefits and services, some of which are wellness, prevention, educational health, and disease management programs. We also may disclose such information in support of plan administration to the following - to Kentucky Teachers' Retirement System as the plan sponsor of the group health plan, as specified in your plan documents; to persons known as business associates who provide services to us and assure us they will protect the information (our TPA, PBM, actuaries and auditors are business associates); to researchers, provided measures are taken to protect your privacy; to state insurance departments, boards of pharmacy, FDA, US Department of Labor, US Department of Health and Human Services and other government agencies that may regulate us; to federal, state and local law enforcement officials for the purpose of law enforcement; in response to a court order or other lawful process regarding legal proceedings; and for the purpose of public welfare to address matters of public interest as required or permitted by law such as threats to public health and safety or national security.

Uses and Disclosures Requiring Your Written Authorization

In situations not specifically permitted under HIPAA and other than those symbolized above, we will ask for your written authorization before using or disclosing personal information about you. If you have given us written authorization, you may revoke it at any time before we act, provided such revocation is in writing.

Member Rights

You have the right to access, inspect, and obtain a copy of your protected health information (PHI) contained in a designated record set that may be used to make decisions about your health care benefits (certain exceptions apply). This PHI may be maintained by our TPA, PBM, or by us. Please write KTRS at the address below to initiate this right. A fee may be charged for the cost of copying, mailing, and other supplies associated with your request. You may make a written request for restriction on certain uses and disclosures of PHI. However, KTRS is not required to agree to a requested restriction. You have the right to receive confidential communications of PHI by alternative means or at alternative locations if the request is reasonable and made in writing. You have the right to submit a written request to have KTRS amend PHI. Amendments will be made by KTRS in cases where such amendments are supported by adequate justification furnished by the member. Upon written request, you have the right to receive an accounting of certain disclosures of PHI, but not for disclosures made before April 14, 2003. The period covered by the accounting can be as long as six years prior to the date on which the accounting is requested. Reasonable fees may be charged if you request such an accounting more than once in a 12-month period. Each member has the right to request a paper copy of this notice from KTRS or make any of the requests above by writing to the address below.

Members may complain to KTRS and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. Complaints to KTRS must be submitted in writing and sent to the Privacy Officer using the address shown below. Federal statutes prohibit any retaliation against a member for filing a complaint regarding violation of health privacy rights.

KTRS Obligations

KTRS is required by law to maintain the privacy of your PHI and to provide members with notice of our legal duties and privacy practices with respect to PHI. KTRS is required to abide by the terms contained in this notice upon its effective date. We reserve the right to change the terms of our privacy notice and to make the new practices effective for all PHI we maintain and will maintain in the future. Members may obtain a copy of any revised notice at www.ktrs.ky.gov or by submitting a written request to the KTRS address shown below.

General Provisions Continued

Written Requests By Mail:	Further Information By Telephone:
Attention: Privacy Officer of KTRS **479 Versailles Road** **Frankfort, KY 40601-3800**	**In Frankfort - 848-8500** **Outside Frankfort - (800) 618-1687**

*** For the purpose of this notice, "KTRS" and the pronouns "we", "us" and "our" refer to the Kentucky Teachers' Retirement System self-funded Medicare Eligible Health Plan. This self-funded health plan has been deemed a covered entity for federal HIPAA privacy purposes.**

DISCLOSURE OF INFORMATION AGREEMENTS
APRIL 13, 2005

KTRS, as a retirement system entity and *Plan Sponsor* of a group health plan, requests and agrees that the KTRS group health plan, known as the MEHP, will disclose information to the Centers for *Medicare* and Medicaid Services (CMS), on behalf of KTRS as a *Plan Sponsor*. The information given by the MEHP to CMS will be only the information necessary for KTRS, as *Plan Sponsor*, to comply with Subpart R of the *Medicare* Modernization Act and to allow for the treatment, payment, and healthcare operations of our respective drug plans and medical plans. This agreement is to act as a codicil to the following:

Amendment to Summary Plan Description Effective April 14, 2003 For Participants in the *Medicare* Eligible Health Plan (MEHP)

Disclosure of Protected Health Information to Kentucky Teachers' Retirement System (KTRS), the *Plan Sponsor* of the MEHP

Effective **April 14, 2003,** the MEHP will become subject to new federal privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rules"). This Amendment describes certain limitations on the disclosure of protected health information by the MEHP to KTRS as a *Plan Sponsor* and the measures KTRS as a *Plan Sponsor* will take to safeguard this information.

For more information on the privacy practices of the MEHP, please refer to the KTRS Notice of Privacy Practices included in this Summary Plan Description.

What is "protected health information"?
"Protected health information" is information about *you*, including demographic information collected from *you*, that can reasonably be used to identify *you* and that relates to *your* past, present or future physical or mental condition. Protected health information is also information about the provision of health care or the payment for that care.

How does KTRS as a *Plan Sponsor* use and disclose protected health information?
KTRS as a *Plan Sponsor* will use or disclose *your* protected health information for the purpose of carrying out plan administrative functions for the MEHP in a manner consistent with the Privacy Rules. Please refer to the KTRS Notice of Privacy Practices included in this Summary Plan Description for a description of these uses and disclosures.

General Provisions Continued

Protected health information will not be disclosed by KTRS as a *Plan Sponsor* for the purpose of employment-related actions or decisions, or in connection with any other benefit plans, unless authorized by the individual. KTRS as *Plan Sponsor* of the MEHP does not have an employer relationship with insured individuals of the MEHP.

Certification from KTRS as a *Plan Sponsor* to the MEHP

The MEHP will only disclose protected health information to KTRS as a *Plan Sponsor* given this certification that KTRS as a *Plan Sponsor* agrees to comply with the following conditions:

- Not to use or further disclose the information other than as described in the KTRS Notice of Privacy Practices included in this Summary Plan Description, or as required by law.
- Ensure that any agents (including a subcontractor) to whom KTRS as a *Plan Sponsor* provides protected health information received from the MEHP agree to the same restrictions and conditions that apply to KTRS as a *Plan Sponsor* with respect to such information.
- Not disclose the protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of KTRS as a *Plan Sponsor*, unless authorized by the individual. KTRS as *Plan Sponsor* of the MEHP does not have an employer relationship with insured individuals of the MEHP.
- Report to the MEHP any use or disclosure of the protected health information that is inconsistent with the uses and disclosures described in the KTRS Notice of Privacy Practices included in this Summary Plan Description of which KTRS as a *Plan Sponsor* becomes aware.
- As required by federal privacy regulations,
  1. Make protected health information available to individuals, including for purposes of amendment;
  2. Incorporate any such amendments; and
  3. Make available the information required to provide individuals with an accounting of certain of *Plan Sponsor's* disclosures of their protected health information.
- Make *Plan Sponsor's* internal practices, books, and records relating to the use and disclosure of protected health information received from the MEHP available to the Secretary of Health and Human Services for purposes of determining compliance by the MEHP with the Privacy Rules.
- If feasible, return or destroy all protected health information received from the MEHP that KTRS as a *Plan Sponsor* still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, but, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.
- Ensure that adequate separation described below in **Separation Between *Plan Sponsor* and the MEHP** is established.

Separation Between KTRS as a *Plan Sponsor* and the MEHP

The following classes of employees of *Plan Sponsor* may be given access to protected health information received from the MEHP or a third party administrator or pharmaceutical benefits manager of the MEHP: Accountants; Administration; Call Center and Reception; Department Directors; Executive Staff; Imaging Specialists; Insurance Coordinators/Managers/Staff; IT Professionals; Member Services Specialists; Retirement Counselors and Support Staff; and Risk Specialist/Cost Containment Specialist.

The classes of employees identified in the preceding paragraph will have access to protected health information solely to perform the plan administration functions that the *Plan Sponsor* performs for the MEHP. Any person who breaches this trust will be disciplined and risks immediate termination. *Plan Sponsor* will take necessary actions to mitigate the harmful effects of any known instances of non-compliance.

General Provisions Continued

The foregoing restrictions do not apply in the following circumstances:

- to protected health information disclosed to *Plan Sponsor* pursuant to a valid authorization from the individual who is the subject of the information;
- to the disclosure of enrollment information to *Plan Sponsor*; or
- to protected health information that has been summarized in conformity with the Privacy Rules that is used for obtaining premium bids from health plans or modifying, amending, or terminating the MEHP.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

ALL CLAIMS MUST FIRST BE FILED WITH *MEDICARE*.

This section describes what a *covered person* (or his or her authorized representative) must do to file a claim for Plan benefits.

- A claim must be filed with the *Plan Manager* in writing and delivered to the *Plan Manager*, by mail, postage prepaid.

- Claims must be submitted to the *Plan Manager* at the address indicated in the documents describing the Plan or *claimant's* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

- Also, claims submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the Plan.

- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 24 months after the date of loss, except if *you* were legally incapacitated. Plan benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the Plan.

- Claims submissions must be complete. They must contain, at a minimum:

    a. The name of the *covered person* who incurred the *covered expense*;
    b. The name and address of the health care provider;
    c. The diagnosis of the condition;
    d. The procedure or nature of the treatment;
    e. The date of and place where the procedure or treatment has been or will be provided;
    f. The amount billed and the amount of the covered expense not paid through coverage other than Plan coverage, as appropriate;
    g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

A general request for an interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the Plan, should be directed to the Plan Administrator.

Claims Procedures Continued

A copy of the *Medicare* Explanation of Benefits (EOB) demonstrating what *Medicare* has paid should be mailed to:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

MISCELLANEOUS MEDICAL CHARGES

If *you* accumulate bills for medical items *you* purchase or rent yourself, send them to the *Plan Manager* at least once every three months during the year (quarterly). The receipts must include the patient name, name of item, date item purchased or rented and name of the provider of *service.*

ASSIGNMENTS AND REPRESENTATIVES

A *covered person* may assign his or her right to receive Plan benefits to a health care provider only with the consent of the *Plan Manager*, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by the *Plan Manager*, then the Plan will not consider an assignment to have been made. An assignment is not binding on the Plan until the *Plan Manager* receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care provider submits claims on behalf of a *covered person*, benefits will be paid to that health care provider.

In addition, a *covered person* may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of Protected Health Information with respect to the claim by the Plan, the *Plan Manager* and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the *Plan Manager*, then the Plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the *Plan Manager* in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which the *Plan Manager* may verify with the *claimant* prior to recognizing the authorized representative status.

- In any event, a health care provider with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by the Plan as the *claimant's* authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the *covered person*, such as whether and how to appeal a claim denial.

Claims Procedures Continued

CLAIMS DECISIONS

After submission of a claim by a *claimant*, the *Plan Manager* will notify the *claimant* within a reasonable time, as follows:

PRE-SERVICE CLAIMS

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the Plan. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information.

URGENT CARE CLAIMS

The *Plan Manager* will determine whether a claim is an *urgent care claim*. This determination will be made on the basis of information furnished by or on behalf of a *claimant*. In making this determination, the *Plan Manager* will exercise its judgment, with deference to the judgment of a physician with knowledge of the *claimant's* condition. Accordingly, the *Plan Manager* may require a *claimant* to clarify the medical urgency and circumstances that support the *urgent care claim* for expedited decision-making.

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination as soon as possible, taking into account the medical exigencies particular to the *claimant's* situation, but not later than 72 hours after receipt of the *urgent care claim* by the Plan.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the Plan, notice will be provided by the *Plan Manager* as soon as possible, but not more than 24 hours after receipt of the *urgent care claim* by the Plan. The notice will describe the specific information necessary to complete the claim.

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.

- The *Plan Manager* will notify the *claimant* of the Plan's *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:

    a. The Plan's receipt of the specified information; or

    b. The end of the period afforded the *claimant* to provide the specified additional information.

Claims Procedures Continued

POST-SERVICE CLAIMS

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination within a reasonable time, but not later than 30 days after receipt of the claim by the Plan.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the Plan. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which the Plan expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information. The *Plan Manager* will make a decision no later than 15 days after the earlier of the date on which the information provided by the *claimant* is received by the Plan or the expiration of the time allowed for submission of the additional information.

TIMES FOR DECISIONS

The periods of time for claims decisions presented above begin when a claim is received by the Plan, in accordance with these claims procedures.

PAYMENT OF CLAIMS

Many health care providers will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, the *Plan Manager* will, in its sole discretion, assume that an assignment of benefits has been made to certain Providers. In those instances, the *Plan Manager* will make direct payment to the *hospital*, clinic, or physician's office, unless the *Plan Manager* is advised in writing that *you* have already paid the bill. If *you* have paid the bill, please indicate on the original statement, "paid by *covered person*," and send it directly to the *Plan Manager*. *You* will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for *you* as required under state Medicaid law.

Benefits payable on behalf of *you* after death will be paid, at the Plan's option, to any *family member(s)* or *your* estate. The *Plan Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the *Plan Manager* in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

Claims Procedures Continued

INITIAL DENIAL NOTICES

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, or by e-mail, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving *urgent care claims* may be provided to a *claimant* orally within the time frames noted above for expedited *urgent care claim* decisions. If oral notice is given, written notification will be provided to the *claimant* no later than 3 days after the oral notification.

A claims denial notice will state the specific reason or reasons for the adverse determination, the specific Plan provisions on which the determination is based, and a description of the Plan's review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the *claimant* to perfect the claim and an explanation of why such material or information is necessary.

The notice will describe the Plan's review procedures and the time limits applicable to such procedures.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on *medical necessity, experimental, investigational or for research purposes* as determined by *Medicare,* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse decision of an *urgent care claim*, the notice will provide a description of the Plan's expedited review procedures applicable to such claims.

APPEALS OF ADVERSE DETERMINATIONS

A *claimant* must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). With the exception of *urgent care claims*, the Plan uses a two level appeals process for all adverse determinations. The *Plan Manager* will make the determination on the first level of appeal. If the *claimant* is dissatisfied with the decision on this first level of appeal, or if the *Plan Manager* fails to make a decision within the time frame indicated below, the *claimant* may appeal to the Plan Administrator (KTRS). In expedited cases, this will be done in 72 hours. *Urgent care claims* are subject to a single level appeal process only, with the *Plan Sponsor* making the determination.

Claims Procedures Continued

A first level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

For Medical Claims:
Humana G&A
P.O. Box 14546
Lexington, KY 40512-4546

A second level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

Attention: Risk Specialist
KTRS
479 Versailles Road
Frankfort, KY 40601

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

A *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *experimental, investigational, or for research purposes*, or not *medically necessary* or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Periods for Decisions on Appeal - First Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims	As soon as possible, but not later than 72 hours after the *Plan Manager* receives the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next 3 days).
Pre-Service Claims	Within a reasonable period, but not later than 15 days after the *Plan Manager* receives the appeal request.
Post-Service Claims	Within a reasonable period but no later than 30 days after the *Plan Manager* receives the appeal request.

Claims Procedures Continued

Time Periods for Decisions on Appeal - Second Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Pre-Service Claims	Within a reasonable period, but not later than 15 days after the *Plan Manager* receives the appeal request.
Post-Service Claims	Within a reasonable period but no later than 30 days after the *Plan Manager* receives the appeal request.

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to *claimants* by mail, postage prepaid, or by e-mail, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will convey the specific reason or reasons for the adverse determination and the specific plan provisions on which the determination is based.

The notice will also disclose any internal Plan rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on a *medical necessity* or *experimental, investigational, or for research purposes* as determined by *Medicare* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, the *claimant* on appeal will be entitled to receive, upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination.

2. Submitted, considered or generated in the course of making the benefit determination.

3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations.

4. That constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment, without regard to whether the statement was relied on.

Claims Procedures Continued

EXHAUSTION

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the *Plan*. If the *Plan Manager* or Plan Administrator fails to complete a claim determination or appeal within the time limits set forth above, the *claimant* may treat the claim or appeal as having been denied, and the *claimant* may proceed to the next level in the review process.

LEGAL ACTIONS AND LIMITATIONS

A civil action may not be brought with respect to *Plan* benefits until all remedies under the *Plan* have been exhausted.

DEFINITIONS

Advance imaging services means Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan.

Alternative medicine means an approach to medical diagnosis, treatment or therapy that has been developed or practiced NOT using the generally accepted scientific methods in the United States of America. For purposes of this definition, *alternative medicine* shall include, but is not limited to: acupressure, acupuncture, aroma therapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

Beneficiary means *you* or legal representative of either, and anyone to whom the rights of *you* may pass.

Benefit Period means a period used to determine coverage for inpatient stays in *hospitals* and skilled nursing facilities. A benefit period *begins* on the first day *you* go to a *Medicare*-covered inpatient *hospital* or a skilled nursing facility. The benefit period *ends* when *you* have not been an inpatient at any *hospital* or skilled nursing facility for 60 days in a row. If *you* go to the *hospital* (or skilled nursing facility) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods *you* can have. The type of care *you* actually receive during the stay determines whether *you* are considered to be an inpatient for skilled nursing facility stays, but not for *hospital* stays.

You are an inpatient in a skilled nursing facility only if *your* care in the skilled nursing facility meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a skilled nursing facility, *you* must need daily skilled nursing or skilled rehabilitation care, or both.

Generally, *you* are an inpatient of a *hospital* if *you* are receiving inpatient services in the *hospital* the type of care *you* actually receive in the *hospital* does not determine whether *you* are considered to be an inpatient in the *hospital*.

Bodily injury means injury due directly to an accident and independent of all other causes.

Calendar year means a period of time beginning on January 1 and ending on December 31.

Case management means the process of assessing whether an alternative plan of care would more effectively provide *medically necessary* health care *services* in an appropriate setting.

Claimant means a *covered person* (or authorized representative) who files a claim.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia;

2. A nonelective cesarean section surgical procedure;

Definitions Continued

3. Terminated ectopic pregnancy; or

4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

1. False labor;

2. Occasional spotting;

3. Prescribed rest during the period of pregnancy;

4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or

5. An elective cesarean section.

Concurrent review means the process of assessing the continuing *medical necessity*, appropriateness, or utility of additional days of *hospital confinement*, outpatient care, and other health care *services*.

Confinement means being a resident patient in a *hospital* or a *qualified treatment facility* for at least 15 consecutive hours per day. Successive *confinements* are considered one *confinement* if due to the same *bodily injury* or *sickness*.

Copayment means the amount to be paid by *you* for each applicable medical *service.*

Cosmetic surgery means *surgery* performed to reshape structures of the body in order to change *your* appearance or improve self-esteem.

Covered expense means *services* incurred by *you* due to *bodily injury* or *sickness* for which benefits may be available under the *Plan*. *Covered expenses* are subject to all provisions of the *Plan*, including the limitations and exclusions.

Covered person means the eligible Kentucky Teacher retiree and eligible spouse.

Creditable coverage means the total time of prior continuous health plan coverage periods used to reduce the length of any pre-existing condition limitation period applicable to *you* under this Plan where these prior continuous health coverage(s) existed with no more than a 63-consecutive day lapse in coverage.

Custodial care means *services* provided to assist in the activities of daily living which are not likely to improve *your* condition. Examples include, but are not limited to, assistance with dressing, bathing, toileting, transferring, eating, walking and taking medication. These *services* are considered *custodial care* regardless if a *qualified practitioner* or provider has prescribed, recommended or performed the *services*.

Definitions Continued

Dental injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. *Dental injury* does not include chewing injuries.

Durable medical equipment (DME) means equipment that is *medically necessary* and able to withstand repeated use. It must also be primarily and customarily used to serve a medical purpose and not be generally useful to a person except for the treatment of a *bodily injury* or *sickness*.

Emergency means an acute, sudden onset of a *sickness* or *bodily injury* which is life threatening or will significantly worsen without immediate medical or surgical treatment.

Expense incurred means the fee charged for *services* provided to *you*. The date a *service* is provided is the *expense incurred* date.

***Experimental, investigational or for research purposes*:**
A *service* is *experimental, investigational or for research purposes* if *Medicare* determines;

1. The *service* cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the *service* is furnished; or

2. The *service* or *your* informed consent document utilized with the *service* was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or

3. Reliable evidence shows that the *service* is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. Reliable evidence shows that the prevailing opinion among experts regarding the *service* is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

5. Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same *service*; or the written informed consent used by the treating facility or by another facility studying substantially the same *service*.

Family member means *you* or *your* spouse, or *you* or *your* spouse's child, brother, sister, parent, grandchild or grandparent.

Free-standing surgical facility means a public or private establishment licensed to perform surgery and which has permanent facilities that are equipped and operated primarily for the purpose of performing *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

Definitions Continued

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;

2. Has a physician and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing *services*;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or

7. Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does not include an institution which is principally a rest home, skilled nursing facility, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of alcoholism, chemical dependence or *mental disorders*.

Maintenance care means any *service* or activity which seeks to prevent *bodily injury* or *sickness*, prolong life, promote health or prevent deterioration of a *covered person* who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee, as determined by *Medicare,* for a *service* means the lesser of:

1. The fee most often charged in the geographical area where the *service* was performed;

2. The fee most often charged by the provider;

3. The fee which is recognized as reasonable by a prudent person;

4. The fee determined by comparing charges for similar *services* to a national data base adjusted to the geographical area where the *services* or procedures were performed; or

5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service,* as adjusted to the geographic area where the *services* or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. No further benefits are payable once the *maximum benefit* is reached.

Definitions Continued

Medically necessary or medical necessity means the extent of *services* required to diagnose or treat a *bodily injury* or *sickness* which is known to be safe and effective by the majority of *qualified practitioners* who are licensed to diagnose or treat that *bodily injury* or *sickness*, as deemed by *Medicare*. Such *services* must be:

1. Performed in the least costly setting required by *your* condition;

2. Not provided primarily for the convenience of the patient or the *qualified practitioner*;

3. Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;

4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

5. Substantiated by the records and documentation maintained by the provider of *service*.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Mental disorder means a mental, nervous, or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, regardless of the cause or causes of the disease or disorder.

Morbid obesity means a body mass index (BMI) of 40 kilograms per mass squared or 100 pounds or more over *your* ideal weight as determined by the Metropolitan Life Height and Weight Tables for Men and Women, as of the date of service.

Orthotic means a custom-fitted or custom-made braces, splints, casts, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a *qualified practitioner*.

Partial hospitalization means those services offered by a program:

1. Must be *medically necessary*; and

2. Not *custodial care*; and

3. Not day-care; and

4. Accredited by the Joint Commission on the Accreditation of Hospitals or in compliance with equivalent standards.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered to be *partial hospitalization* services.

Plan means Kentucky Teachers' Retirement System Medicare Eligible Health Plan.

Definitions Continued

Plan Manager means Humana Insurance Company (HIC). The *Plan Manager* provides services to the Plan Administrator, as defined under the Plan Management Agreement. The *Plan Manager* is not the Plan Administrator or the *Plan Sponsor*.

Plan Sponsor means Kentucky Teachers' Retirement System.

Plan year means a period of time beginning on the *Plan* anniversary date of any year and ending on the day before the same date of the succeeding year.

Post-service claim means any claim for a benefit under a group health plan that is not a *pre-service claim*.

Preadmission testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a *hospital*. The tests must be for the same *bodily injury* or *sickness* causing the patient to be *hospital* confined. The tests must be accepted by the *hospital* in lieu of like tests made during *confinement*. *Preadmission testing* does not mean tests for a routine physical check-up.

Predetermination of benefits means a review by the *Plan Manager* of a *qualified practitioner's* treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of *services***.**

Pre-service claim means a claim with respect to which the terms of the *Plan* condition receipt of a *Plan* benefit, in whole or in part, on approval of the benefit by the *Plan Manager* in advance of obtaining medical care.

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, physician and provider notes and bills and claims with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

Rehabilitation Center means a facility which provides *services* of non-acute rehabilitation. All *services* are provided under the direction of a psychiatrist, a medical doctor with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide *services* of a custodial nature. The facility must be *Medicare* certified licensed by the State Department of Health as a "special hospital" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

Services mean procedures, surgeries, examinations, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of *your* body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body.

Definitions Continued

Sound natural tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);

2. Has not been extensively restored;

3. Has not become extensively decayed or involved in periodontal disease; and

4. Is not more susceptible to injury than a whole natural tooth.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

Urgent care claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function; or

2. In the opinion of a physician with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

3. Generally, whether a claim is a claim involving urgent care will be determined by the *Plan Manager*. However, any claim that a physician with knowledge of a *claimant's* medical condition determines is a "claim involving urgent care" will be treated as a "claim involving urgent care."

Utilization review means the process of assessing the *medical necessity* as determined by *Medicare*, appropriateness, or utility of *hospital* admissions, surgical procedures, outpatient care, and other health care *services.*

You and your means *you* as the *covered person*, unless otherwise indicated.